Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-3760-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TX ASSOC OF COUNTIES RMP Box #: 01	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on Table of Disputed Services: "Letter dated 10-02-07 stating that "you remain entitled to reasonable and necessary medical benefits related to this injury" (copy of letter attached and [sic]) and statement from my Dr. (also attached, stating that "Cymbalta has been prescribed for back pain as of June 24, 2008" When first prescribed I didn't want to take Cymbalta because I thought it was from depression and I wasn't depressed but I decided to try it after find on the internet it is used for back pain. (copy included)"

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Total Amount Sought: $1,400.89

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "This MDR request is for reimbursement of pharmaceuticals, apparently paid for out of pocket by the Claimant. Aside from the one bill that was reimbursed in the amount of $16.23, the remaining bills have never been submitted to the Carrier for payment. Since these bills have been not submitted and consequently not processed by the Carrier, the request for MDR is premature. Therefore, the Carrier asks that this request be dismissed."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
06/12/2008 – 03/28/2009	No EOBs or denials submitted	Out-of Pocket expenses – Untimely submitted	$ 836.36	$ 0.00
04/28/2009 – 07/28/2009	No EOBs or denials submitted	Out-of-Pocket expenses – Prescription Medication	$ 564.53	$564.53
Total Due:			$1,400.89	$564.53

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. Medical Fee Dispute Resolution received the request for medical dispute resolution on April 23, 2010. Dates of service June 12, 2008 through March 28, 2009 were not filed within the one-year filing time as required by 28 Texas Admin Code Section §133.307(c)(1); therefore, these dates of service are not eligible for review.

2. In accordance with 28 Texas Admin Code Section §133.307(c)(3)(D) the Requestor has submitted convincing evidence of an attempt to obtain reimbursement from the carrier. Review of the information submitted with the initial Request for Medical Fee Dispute Resolution (MFDR) and the subsequent submission of the pharmacy log, letter to Adjustor Nancy Picket, dated 11-27-09 and the USPS Return Receipt for certified mail, signed by Chris Hatfield on November 30, 2009, shows the Requestor submitted a request for reimbursement to the Carrier. The additional information was faxed to MFDR on June 9, 2010. The Carrier's agent signed for the additional information on June 22, 2010.

3. The Carrier has not raised any further issues; therefore, as a result, the amount ordered is $564.53.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $564.53 reimbursement.

Authorized Signature	Auditor III Medical Fee Dispute Resolution	July 6, 2010 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.